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No. 95-1395

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, HOWARD MCDOUGALL, *et al.*,
Petitioners,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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REPLY BRIEF OF PETITIONERS

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REPLY BRIEF OF PETITIONERS

I. PETITIONER CENTRAL STATES RAISED THE ISSUE OF ADHERENCE TO THE PLAN LANGUAGE BELOW.

Respondent Pathology Laboratories contends that Central States' Petition raises a new issue, not raised before the Court of Appeals. According to Pathology Laboratories, the "new" issue is whether the written terms of an ERISA plan

> may be modified by means of either oral representations or conduct inconsistent with the terms of the plan.

(Respondent's Brief in Opposition, p. 8.)

It is not true that this issue of adherence to the ERISA plan language was not raised below. Although the opinion of the Seventh Circuit characterized this as an issue raised by Central States "[a]lmost in passing" (Appendix to Central States' Petition, p. 7a), the court's opinion clearly acknowledges that it was faced with an issue of interpreting the written terms of an ERISA plan. (Appendix to Central States' Petition, pp. 7a-8a.)

In fact, Central States argued in its Brief filed in the Seventh Circuit that

> [b]ecause ERISA requires *strict adherence to the terms of the employee benefit plan, any payments by the Central States staff that deviate from the plain language of the employee benefit plan* must be presumed to be based upon a mistake. . . . The payments to Pathology Laboratories were outside the plan terms, and therefore constitute mistaken overpayments.

(Seventh Circuit Brief and Short Appendix of Appellant Central States, p. 21, excerpts included in the Addendum filed with this Reply, Addendum, p. 2a; emphasis added.)

Central States also argued before the Seventh Circuit that it had already been definitively established in this case that the plain language of the Central States Plan Document excluded coverage for Pathology Laboratories' "professional component" charges. Therefore, Central States argued, any payments which Central States' staff made in the past for those charges were excess payments, and had to be refunded under the provisions of Central States' Plan. Central States' Seventh Circuit Brief stated:

> The terms of the Central States Plan Document which, pursuant to 29 U.S.C. § 1132(a)(3), Central States is seeking "*to enforce*", do not hinge on an analysis of who was at fault in making the overpayment to Pathology Laboratories. Article 11.04 of Central States Plan provides:

> *ARTICLE 11.04 Recovery of Excess Payments*
>
> Whenever this Plan has made payments *exceeding the amount of benefits payable under the terms of this Plan*, the Fund shall have the right to recover the excess payments from any responsible person or entity, including the right to deduct the amount of excess payments from any subsequent payable benefits.
>
> * * * *
>
> As we have seen, [the district court] ruled in this case that the Central States plan unambiguously states that the provision of a "treatment" is a prerequisite for any sort of coverage, and that Pathology Laboratories' "professional component" services do not constitute "treatment" of a Central States participant. Pathology Laboratories has not appealed this ruling by [the district court]. Therefore, the payments for the professional component charges which Central States seeks to have refunded in this case were "payments exceeding the amount of benefits payable under the terms of this Plan," within the meaning of the Plan's refund provision, Article 11.04, *supra*.

(Central States' Seventh Circuit Brief, pp. 31-32, Addendum hereto, pp. 5a-6a; emphasis added; citations omitted.)

Finally, Central States argued before the Seventh Circuit that "ERISA requires strict adherence to the written terms of the employee benefit plan [*citing* 29 U.S.C. § 1104(a)(1)(D)]", and that "[d]eviation from the written plan terms undermines the actuarial assumptions and financial stability of the ERISA benefit plans." (Central States' Seventh Circuit Brief, p. 26, Addendum hereto, pp. 3a-4a.)

Nevertheless, in this case the Seventh Circuit sanctioned a plan "interpretation" that—as the court's opinion seems to acknowledge—diverts from the express coverage terms of the plan. The Seventh Circuit found that there had been "detrimental reliance" on the part of Pathology Laboratories which justified deviation from the

coverage terms which were otherwise clear and unambiguous. In so ruling, the court rejected Central States' express arguments that the ERISA plan language must control.

This, in turn, places the Seventh Circuit at odds with the circuits holding that principles of detrimental reliance and estoppel cannot alter the plain language of an ERISA plan. (Central States' Petition, pp. 14-15.)

II. THE SEVENTH CIRCUIT USED EXTRINSIC EVIDENCE TO "INTERPRET" PLAN LANGUAGE WHICH WAS CLEAR ON ITS FACE.

Pathology Laboratories argues that in this case the Seventh Circuit only used extrinsic evidence (*i.e.*, evidence of the prior payment practices of Central States) to "interpret" the Central States Plan Document, not to "modify" that document:

> Because the court found that Central States made the payments knowingly rather than by mistake, it concluded that the payments were not "excess payments" within the meaning of Article 11.04 [the plan's refund provision]. Nothing in the court of appeals' opinion holds that the Central States plan could be "modified" by a course of conduct.

(Respondent's Brief in Opposition, p. 9.)

But there is no real difference in this case between using extrinsic evidence to modify a plan, and using it to "interpret" a plan. The result is the same: the express terms of the plan were ignored in favor of the course of conduct or other extrinsic circumstances.

Further, Pathology Laboratories' argument (quoted above) candidly admits that the Seventh Circuit used evidence of a course of conduct between the parties to determine what constitutes an "excess payment." But the actual plan language left no doubt that the payments to Pathology Laboratories were not covered by the Central

States plan, and that therefore those payments were in excess of the amounts allowed under the plan.

A court may decide, based upon a course of dealing between the parties, that particular payments for a particular class of medical bills are not in excess of the allowed coverage under a plan. But if there is plan language that clearly excludes coverage for those charges, the court cannot claim that it is *following* the plan language.

Thus there is an obvious nexus between the Central States plan language which requires refunds of excess payments (Article 11.04), and the coverage terms of the plan. Because all parties, as well as the Court of Appeals in the opinion below, are agreed that the Central States Plan Document is clear in excluding coverage for Pathology Laboratories' charges, Central States' prior payments of those charges were "excess payments." That is why Pathology Laboratories is so far off the mark in saying that Article 11.04 is "the *only* provision that was material to the issues on appeal." (Respondent's Brief in Opposition, p. 13; emphasis added.)

III. THE SEVENTH CIRCUIT RULING CONCERNING THE COURSE OF CONDUCT BETWEEN THE PARTIES AND DETRIMENTAL RELIANCE IS NOT AN ALTERNATIVE HOLDING.

Finally, Pathology Laboratories contends that the Seventh Circuit's discussion of the impact of detrimental reliance upon the interpretation of plan language is either dicta or an "alternative holding." (Respondent's Brief in Opposition, p. 11.) But it was impossible for the Seventh Circuit to have ruled against Central States without attempting to reconcile Article 11.04 of the Central States Plan Document—which mandates refunds to Central States of any excess payments—with the Central States Plan provisions which clearly exclude payment for charges of the sort made by Pathology Laboratories in

this case. As we have seen, the Seventh Circuit accomplished this interpretive task by allowing the course of dealing between the parties, rather than the text of the Plan Document, to dictate the meaning of the Central States Plan. Although Central States believes that this constitutes a dangerous precedent under ERISA, the reasoning of the Seventh Circuit on this issue formed a vital support for the court's final conclusion. This was no mere judicial adornment or surplusage. Without the proposition that "excess payments" under the plan are defined by the course of dealing between the parties, the edifice built by the Seventh Circuit tumbles.

In short, the Seventh Circuit was well aware that this was an ERISA case under 29 U.S.C. § 1132(a)(3) to "enforce" the terms of the Central States plan. However, along the way the court lost sight of the proper means of plan interpretation, and permitted the history of the dealings between the party, rather than the plain language of the Central States Plan Document, to determine whether particular payments were in excess of allowable coverage.

It is telling that Pathology Laboratories makes no response to Central States' contention that the statutory text and the underlying purpose of ERISA demand that any judicial interpretation of a benefit plan remain faithful to the objective meaning expressed in the plan language. (Central States' Petition, pp. 18-19.) Unless the interpretation is based upon the objective standard provided by the plan language, certainty in determining employee benefits will be eroded, along with the actuarial assumptions and ultimate financial stability of employee benefit plans. (*Id.*)

CONCLUSION

For these reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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May 8, 1996

ADDENDUM

ADDENDUM

[Excerpts from Petitioner Central States Brief]

UNITED STATES COURT OF APPEALS
FOR THE 7TH CIRCUIT

Case No. 95-2171

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AND MARION M. WINSTEAD, RAY CASH, R. JERRY COOK, HAROLD D. LEU, ROBERT J. BAKER, HOWARD MCDOUGALL, R. V. PULLIAM, SR., AND ARTHUR H. BUNTE, JR., its trustees,

Appellants,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,

Appellee.

Appeal from the United States District Court
for the Northern District of Illinois
JUDGE ELAINE BUCKLO
No. 92 C 4141

BRIEF AND SHORT APPENDIX OF
APPELLANT CENTRAL STATES

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SUMMARY OF ARGUMENT

To the extent that Judge Bucklo found that Central States failed to prove that it paid the "professional component" charges due to a mistake of fact, her findings are clearly erroneous. In deciding the *coverage* issue, Judge Duff held in this case that the Central States plan document unambiguously requires the provision of a treatment or service *to a Central States participant* prior to allowing coverage for any charge. Judge Duff also held that Pathology Laboratories provided no such treatment or service to support its "professional component" charges. Pathology Laboratoreis has not appealed these rulings by Judge Duff in connection with the coverage issue. Because ERISA requires strict adherence to the terms of the employee benefit plan, any payments by the Central States staff that deviate from the plain language of the plan must be presumed to be based upon a mistake—at least in the absence of proof that Central States or its fiduciaries intended to commit a deliberately unlawful breach of the clear plan terms. The payments to Pathology Laboratories were outside the plan terms, and therefore constitute mistaken overpayments.

Further, the uncontradicted oral testimony and documentary evidence showed that Central States' claims payment staff originally was trained to believe that Pathology Laboratories performed a specific service in reviewing or interpreting each of the tests listed on the carefully itemized "professional component" bills. This unrebutted evidence of the subjective state of mind

B. THE DISTRICT COURT'S RULING ON THE REFUND ISSUE SHOULD BE REVERSED.

1. To the extent the district court found that Central States had not proved a mistake of fact, the court's findings are clearly erroneous.

Most of Judge Bucklo's findings on the refund issue are addressed to whether Central States "*ought to have*

known" that the itemized professional component bills were not supported by patient-specific services (Short App., p. 4), or whether the bills "*should have made* [*Central States*] [suspicious" (Short App., p. 6; emphasis added)). However, at one point Judge Bucklo stated:

> I think on the issue *of whether there was a mistake*, I don't think that Central States has proved its case.

(Short App., p. 6; emphasis added.) In context, it appears that the real thrust of Judge Bucklo's ruling is that Central States *did* make a mistake, but should have known better, and therefore was, in her view, unworthy of receiving a refund of the mistaken payments.

If Judge Bucklo actually meant to hold that Central States did not establish that the payments were made by mistake, that finding cannot possibly be correct. Judge Duff (who, as noted, was originally assigned to this case), correctly held in his ruling on the coverage issue that Central States' plan document unambiguously requires the provision of a treatment or service to a Central States participant before medical coverage can be granted under the plan. (Short App., p. 22, citing Section 4.11 of the Central States Plan Document, App., p. 124.) There is no basis to believe that in originally deciding to pay the professional component Central States was acting in intentional disregard of this express plan provision. Why should Central States intentionally make payments to a group of pathologists in Little Rock, Arkansas while fully cognizant that the pathologists were not performing a service for the Central States participants? ERISA requires strict adherence to the written terms of the employee benefit plan. 29 U.S.C. § 1104(a)(1)(D).[4] *See*

---

[4] Section 1104(a)(1)(D) of the Labor Title states that a plan administrator

> shall discharge his duties with respect to a plan solely in the interest of the *participants and beneficiaries* and—
>
> (1) *in accordance with the documents and instruments governing the plan.* . . .

29 U.S.C. § 1104(a)(1)(D) (emphasis added).

also Vershaw v. Northwestern National Life Insurance Co., 979 F.2d 557, 559 (7th Cir. 1992). Deviation from the written plan terms undermines the actuarial assumptions and financial stability of ERISA benefit plans. *Cummings v. Briggs & Stratton Retirement Plan*, 797 F.2d 383, 389 (7th Cir. 1986). Therefore, in the absence of evidence of a deliberately unlawful attempt by the plan fiduciaries to act in disregard of the terms of the plan, any deviation from the express terms of the plan must, by definition, be a mistake.

Second, all the evidence concerning the subjective intent and state of mind of the Central States staff indicates that, at least prior to the March 1989 memo from Dr. Buckingham (Central States' medical consultant, App., p. 179), Central States' staff fully damages. (App., p. 275.) *See Hartford Accident & Indemnity Company v. Chicago Housing Authority*, 12 F.3d 92, 97 (7th Cir. 1993) (insurer can recover amounts paid under a mistake of fact); *Harnischfeger v. Harbor Ins. Co.*, 927 F.2d 974, 978 (7th Cir. 1991) (insurer that conferred benefit due to a mistake of fact should be allowed to seek a refund of the benefit).

2. The refund issue does not turn on whether Central States "ought to have known" that Pathology Laboratories' itemized bills were not based upon the specific services listed in the bills.

The basic point of the district court's opinion appears to be that Central States *should* have known better than to pay the professional component charges. However, that is not the correct legal standard to apply in an ERISA benefits refund or restitution case.

This case falls under 29 U.S.C. § 1132(a)(3), which provides that a civil action may be brought "by a participant, beneficiary *or fiduciary* . . . to obtain appropriate equitable relief . . . *to enforce any provisions of* [*ERISA*] *or the terms of the plan.*" (emphasis added). *See Cen-*

tral States v. Neurobehavioral Associates, P.A., 53 F.3d 172, 173 (7th Cir. 1995). In the *Neurobehavioral* case, the mistake at issue involved a clerical error by a Central States claims adjuster; the adjuster mistakenly typed a payment approval in the amount of $10,000 for a $100 claim. 53 F.3d at 172. Clearly this error was solely the fault of Central States and its agent (the claims adjuster), but the Court nevertheless held that Central States could proceed with its refund claim under 29 U.S.C. § 1132(a)(3). 53 F.3d at 173.

The terms of the Central States Plan Document which, pursuant to 29 U.S.C. § 1132(a)(3), Central States is seeking "to enforce", do not hinge on an analysis of who was at fault in making the overpayment to Pathology Laboratories. Article 11.04 of Central States Plan provides:

> *ARTICLE 11.04 Recovery of Excess Payments*
>
> Whenever this Plan has made payments exceeding the amount of benefits payable under the terms of this Plan, the Fund shall have the right to recover the excess payments from any responsible person or entity, including the right to deduct the amount of excess payments from any subsequent payable benefits.

(App., p. 127.) This plan term merely requires proof that a payment was made "exceeding the amount of benefits payable under the terms of this Plan"; there is no requirement that the Central States staff be free of fault in making the mistaken payment.

As we have seen, Judge Duff ruled in this case that the Central States plan unambiguously states that the provision of a "treatment" is a prerequisite for any sort of coverage, and that Pathology Laboratories' "professional component" services do not constitute "treatment" of a Central States participant. (Short App., p. 22.) Pathology Laboratories has not appealed this ruling by Judge Duff. Therefore, the payments for the professional com-

ponent charges which Central States seeks to have refunded in this case were "payments exceeding the amount of benefits payable under the terms of this Plan," within the meaning of the Plan's refund provision, Article 11.04, *supra*. "Enforcement" of this ERISA Plan refund provision, as mandated by 29 U.S.C. § 1132(a)(3), requires that Pathology Laboratories disgorge the overpayments it received, without regard to who was at fault in causing the overpayments.

This result accords with existing common law rule in most states. In *Harnischfeger v. Harbor Insurance Co.*, 927 F.2d 974, *supra*, this court applied Wisconsin law and held:

> *it is not relevant that the insurer would not have made the mistake had it conducted a better investigation.* See also *Restatement* § 59 ("A person who has conferred a benefit upon another by mistake is not precluded from maintaining an action for restitution by the fact that the mistake was due to his lack of care."). To treat [the insurer's] error as an absolute bar would be to compel an insurer to reserve its rights expressly as a condition of recoupment, a position Wisconsin has abandoned.

927 F.2d at 978 (emphasis added; citations omitted).[5] This rule is founded on sound public policy grounds; it is designed to encourage insurers to pay claims promptly in the first instance:

> [D]enying an insurer the recovery of a payment made erroneously will cause the insurer to resolve all doubts regarding payment against the insured. . . .

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[5] To the extent an express reservation of rights *is* required, the Central States plan provisions, which contain a "no fault" refund rule and which are binding on Pathology Laboratories as a Central States beneficiary, provide such an express reservation.